GIRAME MEETING

NOTES FOR A CRITICAL REVIEW OF THE BAMAKO INITIATIVE

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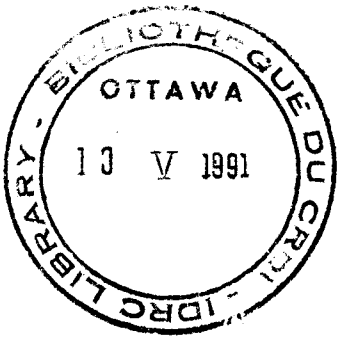

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of recession and economic adjustment policies set by the IMF and the World Bank.

The proponents for BI claim a few successful experiences in which the initiative is based: the PAHOU project (Benin) is one of the most often quoted among others. But in fact there are many experiences for PHC community financing that started in the second half of the '70s. Cameroon, Ghana, Mali, Niger, Nigeria, Senegal, Tanzania, Sudan and Zaire are countries, where NGOs, religious organizations or governmental programs of different styles and sizes, have been in progress (some of these were initiated in 1955 or even earlier like the Aga Khan Health Services in Tanzania, which started in 1941).

The supporters of the BI are quick to assert that the principles of "equity" are not at risk. There are other notions attached to the initiative: revitalization of PHC; decentralization to the district level and community participation. Other recurrent concepts in the BI discourse are the purchase and distribution of "essential drugs", and the promotion of a "rational use of drugs". Most, if not all, of these notions are centred around Western conceptions about health care and the utilization of modern pharmaceuticals.

In short, it seems to me that the BI represents a set of debatable principles and undefined notions, which underestimated a wealth of participatory experiences in Africa and other developing regions, sometimes manipulated and often misinterpreted many of the research findings. I contend that the BI -as it stands- is largely based in Western medical traditions, which are at least controversial and may negatively affect the goals of equity, comprehensive PHC and genuine social participation in health and development. From this perspective, the following are the major limitations and debatable points I propose to discuss briefly in this presentation:

- the BI cannot be seen in isolation. The BI should be seen as part of a larger frame of initiatives: the GOBI-FFF selective PHC approach for MCH, and the structural adjustment policies emanating from the World Bank and the IMF.

- the selective PHC which BI belongs to, represents in the long run the depolitization (decontextualization) of health and the naturalization of poverty.

- the BI tends to reinforce the equivocal image that health could be improved through the increased availability of medical resources. Availability of drugs and pharmaceuticals are seen as a visible and tangible proof of increasing well

being. This image is deeply rooted in the biomedical model of health, which some authors have identified as "commodified health". In exporting the Western model of health care, commodified health plays an important role as a fetish of modernization (Nichter, 1989), reinforcing the reductionistic causation model of disease (one agent, one disease) and the decontextualisation (depolitization) of health.

The commodification of health and the naturalization of poverty.

In discussing the consequences of health commodification for community health, Mark Nichter asserts that:

> "A false sense of security has emerged from the exaggerated claims of curative and preventive health fixes. At the time of environmental deterioration, rapid urbanization and industrialization, a mystification of health has occurred resulting in a depreciation of social responsibility ... Health has been decontextualized and medicalized. It has been turned into an individual pursuit in which commodified health is purchased in the form of medicines and doctor-patient encounters are reduced to an exchange of drugs as the measure of a meaningful transaction. Embodied in such a transaction

> is an ideology consistent with a set of values associated with consumerism and the growth of the capitalist state. In community health terms, the (social) cost of such growth is high." (text in parenthesis mine. Nichter, 1989: p 262-263).

Heavy reliance on medications to treat common symptoms and morbidity episodes such as colds, cough and diarrhoea, parasite infestations, etc. results in "...a cycle of disease-treatment-disease" that will largely benefit the pharmaceutical companies but does not alter the situation under which people live, neither the nutritional and environmental conditions which account for much of their illnesses (Ferguson, 1988). Further, if the people ~~has~~ have to bear the cost of this cycle, resources are drained away, without providing in return any improvement in the living conditions of the population.

This is not the place nor the time to discuss at length the inadequacies of the selective PHC approach to health, but let me briefly summarize the main reservations I hold, with respect to this approach for the African (and other regions) countries:

- the GOBI-FFF set of interventions are essentially medical solutions to social problems. It claims that selective medical

interventions can improve health indices without necessarily improving the social and natural environment.

- the overall strategy of selective PHC focuses on products not processes. The products (i.e. ORS, contraceptives, drugs, vaccines, etc) are introduced into communities via mass media campaigns, and social marketing approaches -as in the case of the BI- where direct payment for drugs is justified as a mechanism for cost recovery and financing of health care. The approach of introducing medical technologies (such as drugs and pharmaceuticals) through social marketing techniques is a risky enterprise and should not be considered harmless. The patterns of prescription (both professional and "over the counter") and self-medication are already affected by a growing number of pharmaceutical products in the "official list" of Ministries of Health, the growing smuggling of modern drugs (faked or real) and the marketing techniques being used for introducing medicinal drugs through conventional outlets and other commercial channels. It has been widely recognized, that the range and number of medicinal products made available is significantly influenced, if not largely determined, by the profit needs of the industry, not the health needs of the country as defined by epidemiological or nutritional data.

- the social marketing plus selective medical interventions approach, with intensive use of technologies usually produced at the centre far from the village, undermines the utilization of indigenous skills and local medical knowledge, further implying that diseases are not socially determined, but result from ignorance and poor hygienic habits of individuals (the blame of the victim).

- it has been widely recognized -both in traditional and modern societies- that medicinal drugs are not the only form of therapy. There are many others, from surgery to exorcism, from meditation to fasting and praying. But perhaps the most important difference lies in that most therapies are generated and delivered within the family setting or the community, or administered by an specialist (i.e. surgery or exorcism), while the medicinal drugs could be prescribed and used (and this is often the case in developing countries) independently from a practitioner, usually as a form of self-care. This has been described as the "paradox of self-care", that is the use of self-prescribed medicines implies greater self-reliance in one sense, but less in another (Whyte and Van der Geest,1988), which is another form of dependency: a distant dependency with the manufacturer and the pharmaceutical industry.

- the S-PHC/social marketing approach incorporates health technologies manipulating community organizations in order to transform them into instruments for the delivery of a "package" (Kanji, 1989). The participation of people and local organizations are seen as conduits, or delivery points. This kind of community participation is instrumental and not transformative. People are seen as "acceptors" and/or "users", "respondents" of KAP surveys at best and "recipients" of messages, but not as transformers of their own situation, co-makers of decisions regarding the introduction and utilization of health technologies.

Although is difficult to find reliable statistics, marketing surveys suggest that developing nations account for about 20% of the world pharmaceutical consumption and that there is considerable variation among the various regions: medicines consumption is significantly higher in Latin America and Asia, than in Africa.

The provision of manufactured drugs and pharmaceuticals in large scale should undoubtedly have effects on local medical traditions and the existing health-seeking processes at the family and the community level: the decision making at the household level, the patterns of therapy seeking, the popular and folk explanatory models, etc... There are many studies focusing on the consequences for human health of promotional

and sales practices, the impact of pharmaceuticals on public health budgets in Third World countries, but relatively little attention has been paid to the effects of pharmaceutical industries on alternative medical traditions or means of coping with illness (Ferguson, 1988).

In short, the selective approach of the BI represents the commodification of health and the naturalization of poverty. The approach often results in the infatuation of Ministries of Health with the 'quick fix' social marketing and selective PHC seem to offer (Wisner, 1988). This set of principles are usually based in very tenuous or even contradictory research evidence.

Cost recovery and community financing mechanisms.

Let me turn now the analysis to the economic perspectives of the BI: the issues of cost recovery systems and drug revolving funds.

Any cost recovery system would discriminate against a considerable proportion of the poor sectors of the population, perhaps those in greatest need for services. Many studies have reported a clear reduction in the use of health services, after the introduction of any form of payment. For instance, Yoder (1989)

reported significant decline in overall patient use of health services in Swaziland, following a nationwide increase in user fees. Following the fees increase, average attendance decreased at government facilities by 32.4% and increased in Mission facilities by 10.2%, leading to an overall decrease of about 17%. When looking at patient visits for basic and preventive services such as inmmunizations (BCG and DPT) or oral rehidration visits, the average attendance declines were -18% and -24% respectively.

The strategies for cost recovery inevitably reduces the role of the state, transferring the costs and responsibilities from governments to people. It encourages the privatization of health and separates health from economic and social development...
On the other hand, people's willingness to pay does not reflect their ability to pay for services (if some incur in large debts for paying private medical care and drugs it represents the no choice situation). Thus, while the "willing and able to pay" rationale may be shown has one of the main arguments for introducing fees for drugs and/or services, it raises many questions, so far unanswered in the BI. For instance, what happens when "willing and alble to pay data" are dissagregated by different groups of users, by different ethnic and socioeconomic groups or by type of services (I.E. preventive vs curative)? When fees are raised, how are the costs and benefits distributed across the population? (Yoder, 1989). What is the the impact of cost recovery in prescription

patterns and how does it affects the quality of services? What is the impact of higher fees on services utilization and on the morbidity and mortality levels of the population, among the different social classes and ethnic groups?

The implementation of an efficient and equitable cost recovery system (i.e. revolving drug fund) for PHC requires fairly sophisticated planning and managerial capabilities to overcome the logistical problems derived from operating under extremely unstable conditions (i.e. high inflation rates, poor communications, fuel shortages, political instability, etc) prevailing in developing countries. (i.e.since revenues are likely to be in local currency, how is this going to help the purchase of drugs overseas in a high inflation economy). Reliable and periodic information on quantities and revenues by drug will be required to determine the current prices to be charged. This could be complicated further when there are subsidies and surcharges for certain drugs or treatments to be detracted, and exemptions for certain groups. The administration of all these may turn to be chaotic; and misappropriation and/or mismanagement of funds could easily occur

BI fails to specify who will decide how the money from drugs are to be used. It is the community representatives or the health services personnel who decides who pays, how much, and what will be the destiny of the revenues ? Discretionary powers are going to

rest with the health staff who will come under strong pressure to exempt payment for friends, relatives or others whom they feel obliged. To be classified under "indigent" or any other category represents another stigma for people to feel humiliated or discriminated against.

Under the influence of a large number of medicinal drugs, what will be the resulting configuration of the local health services and programmes ? If the whole system is going to be centred on drugs and modern pharmaceuticals, most likely the emphasis will be on curative rather than preventive programs.

Finally, if salaries of the health personnel are going to be dependent on drug/treatment cost-recovery profits, then prescription patterns are going to be heavily distorted, favouring the use of certain drugs and procedures. If promotion and prevention are going to be administered free of charge, then we can actually be distorting the composition of services delivered, with negative consequences for the PHC system as a whole.

In closing, let me make a final comment in reference to the notion of cost recovery and community financing:

We should recognize that cost recovery and "drug revolving fund" have different connotations, and should not be considered the

only community financing method. In fact, there are three main strategies for community financing: direct payment for drugs, fee-for-services and health insurance.

If according to some official estimates (World Bank) the 1990-1995 GNP of low income African countries is going to be even lower than in 1973-1980, (the growth rate of GNP for low income sub Saharan Africa 1965 to 1983 was - 0.25%) the dilemma is double. First, how people are going to pay for it ? and second, how is the government going to pay for it ? (a large public sector with average shares of public health expenditures in GNP of 0.95 and 1.9% for low and middle income sub-Saharan Africa).

In facing this dilemma the obvious alternatives for community financing are as follows:

-extra taxes for health (income and consumption);

-lotteries (not very dependable, and even regressive since largest participation comes from low income groups);

-re-allocation of government budget (i.e. from defense or general administration, a proposal very hard to implement);

-direct payment: user charges for health services or pre-payment;

-community financing with some degree of involvement in the organization of the financing scheme, in the allocation of resources, in the administration of the revolving fund, etc.

Within this set of alternatives the last strategy seems to me the most acceptable one, provided that drugs are not the ONLY reason for charging the community. In fact, education, nutrition, water or preventive services should be as important as drugs and pharmaceuticals.

As a final point, I would like to suggest that in any financing strategy, the community should be involved in establishing and monitoring the rules of the game. In particular, the perceptions and the point of view of the people about the trustworthiness of the management of the system, the judgement on the ability to pay, the complete local recycling of funds, and their interpretation of equity, all need to be considered in selecting and implementing a set of community financing strategies (Carrin, 1987). Minimum knowledge in accounting and management of revenues is essential in the direct payment financing scheme (fee-for-service requires additional capacity to cost inputs and set of

appropriate fees; pre-payment strategies needs actuarial knowledge).

Above all, more research is needed regarding the effects of modern pharmaceuticals in health care systems, and the impact of the introduction of medicinal drugs on mortality and morbidity profiles in developing market economies. On the same vein, more in-depth information about the population's socioeconomic status and its preferences, including their health seeking behavioral model and their actual managerial capabilities are badly needed, BEFORE policy decisions and top-down "initiatives" are formulated on how to finance a health care system in a given country or community.